



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DENTON SURGICARE

Respondent Name

ARCH INDEMNITY INSURANCE CO

MFDR Tracking Number

M4-17-3843-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

AUGUST 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim be paid in accordance with the 2017 Texas Workers Comp Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Requestor's Supplemental Position Summary: "We did receive a payment but the carrier is saying they overpaid by \$201.28. I think we need a decision to determine what the correct payment is."

Amount in Dispute: \$439.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our records show that we have made full payment to the provider and in fact there is an overpayment in the amount of \$201.28 for which we will be seeking reimbursement. I have also contacted the provider and requested that they withdraw the dispute."

Respondent's Supplemental Position Summary: "Per the attached dispute, a total of \$641.06 is due. Per Risk-Facts, this amount has now been paid, as of 08/23/17."

Response Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2017	Ambulatory Surgical Care for CPT Code 62323	\$439.78	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - P300-The amount paid reflects a fee schedule reduction.
 - Z710-The charge for the procedure exceeds the fee schedule allowance.

Issues

1. What is the applicable fee guideline?
2. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.
2. The requestor is seeking additional reimbursement of \$439.78 for CPT code 62323.

28 Texas Administrative Code §134.402(d) states,

For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

28 Texas Administrative Code §134.402(f)(1)(B) states,

The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.

According to Addendum AA, CPT code 62323 is a non-device intensive procedure.

The Medicare fully implemented ASC reimbursement for code 62323 CY 2017 is \$273.83.

To determine the geographically adjusted Medicare ASC reimbursement for code 29827:

The Medicare fully implemented ASC reimbursement rate of \$273.83 is divided by 2 = \$136.92.

This number multiplied by the City Wage Index for Denton, Texas is $\$136.92 \times 0.9895 = \135.48 .

Add these two together = \$272.40.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

$\$272.40 \times 235\% = \640.14 .

The total allowable for ambulatory surgical care services for CPT code 62323 is \$640.14. The respondent paid \$5641.06. As a result, additional reimbursement is not recommended of \$356.56.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

11/17/2017
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.